REVIEW OF SYSTEMS-ADOLESCENT

Please take a moment to complete the following. ***In the last 3 months*** have you experienced any of the following? Please indicate Yes or No and ***explain*** if appropriate.

GENERAL	Yes	No	Please explain further.
	❑	❑	Recurrent fever or chills?
	❑	❑	Unintentional weight loss?
	❑	❑	Recurrent fatigue or malaise?
NEUROLOGIC	**Yes**	**No**	
	❑	❑	Frequent dizziness?
	❑	❑	Fainting?
	❑	❑	Weakness in arms or legs?
CARDIAC	**Yes**	**No**	
	❑	❑	Shortness of breath with normal activity?
	❑	❑	Palpitations (sensation of heart beating in your chest)?
SKIN	**Yes**	**No**	
	❑	❑	Rash ?
	❑	❑	New skin lesions, lumps or bumps?
	❑	❑	Moles that are changing color or size?
HEENT	**Yes**	**No**	
	❑	❑	Headaches that are new or changing in frequency or severity?
	❑	❑	Non-healing mouth sores?
	❑	❑	Swollen glands or neck lumps?
RESPIRATORY	**Yes**	**No**	
	❑	❑	Cough that is ongoing, produces phlegm or is changing?
	❑	❑	Difficulty breathing?
	❑	❑	Wheezing?
	❑	❑	Do you smoke or are you exposed to 2nd hand smoke?
GASTROINTESTINAL	**Yes**	**No**	
	❑	❑	Heart Burn or Acid Reflux
	❑	❑	Recurrent nausea or vomiting?
	❑	❑	Recurrent diarrhea or constipation?
	❑	❑	Recurrent abdominal pain or cramping?
GENITOURINARY	**Yes**	**No**	
	❑	❑	Pain with urination?
	❑	❑	Dark or reddish urine?
MUSCULOSKELETAL	**Yes**	**No**	
	❑	❑	Painful or swollen joints? (If yes, which ones?)
INFECTIONS	**Yes**	**No**	
	❑	❑	Do you feel you are at risk for HIV infection?
	❑	❑	Have you ever been exposed to or treated for tuberculosis?
	❑	❑	Have you ever had a blood transfusion?
	❑	❑	Sexually transmitted diseases?
INJURY PREVENTION	**Yes**	**No**	
	❑	❑	Do you wear sunscreen in the sun?
	❑	❑	Are you frequently exposed to loud noises, such as concerts, earphones or machinery?
	❑	❑	Do you wear a seatbelt when riding in a car, truck or van?
	❑	❑	Do you wear a helmet when skateboarding, rollerblading or riding a bicycle or scooter?

TURN OVER AND COMPLETE OTHER SIDE

NAME_____ DATE _____ PROVIDER REVIEW_____

In the last 3 months have you experienced any of the following? Please indicate Yes or No and ***explain*** if appropriate.

REST & RECOVERY	**Yes**	**No**	
	❑	❑	Do you have trouble falling or staying asleep
	❑	❑	Do you wake feeling rested?
	❑	❑	How many hours per day do you watch TV or use a computer.
	How would you rate your energy on a scale of 1-10, with 10 being the most energy?		
	How many hours of sleep do you get on average?		
STRESSORS	**Yes**	**No**	In the past year have there been any changes in your family? (check all that apply)
	❑	❑	Marriage
	❑	❑	Separation or Divorce
	❑	❑	Loss of Job
	❑	❑	Move to new neighborhood
	❑	❑	Change to new school
	❑	❑	Birth
	❑	❑	Serious Illness
	❑	❑	Death
	❑	❑	Other changes/stresses? (explain)
GYNECOLOGIC (FEMALE)	YES	NO	
	❑	❑	Have you ever had a menstrual period? If YES, when was your last menstrual period? _____
	❑	❑	Painful or heavy menstrual periods?
PSYCHOLOGICAL	**Yes**	**No**	
Read Carefully ->	❑	❑	Do you feel safe at home?
	❑	❑	Anxiety?
	❑	❑	Little interest or pleasure in doing things?
	❑	❑	Feeling Down, Depressed or Hopeless?
	❑	❑	Suicidal thoughts?
	❑	❑	Social problems that you feel interfere with your mental or physical health?
	During the PAST 12 MONTHS, did you:		
	❑	❑	Drink any alcohol (more than a few sips)?
	❑	❑	Use any marijuana?
	❑	❑	Use anything else to get high?("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")

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PROVIDER REVIEW_____

Please email completed form to tcmadmin@tcreekmed.com
or fax to 877 512-3804